Letters

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NHS Direct

Doctors may gain time to use their true skills if people start using NHS Direct

Editor—O'Cathain et al's paper confirming that advice offered by nurses through NHS Direct was useful to callers[1] should make us question the generally hostile opinions on this service propounded in free publications that derive their income from pharmaceutical advertising.[2]

Telephone advice can form an important part of an NHS that needs to meet people's concerns, even if some of these concerns seem trivial to doctors working under pressure. The primary end point of NHS Direct should be whether it meets the needs of its callers for information not whether it reduces work for any sector of the medical profession. If an increasingly information hungry population cannot get information from the NHS it will turn to other sources, which may be less reliable or relevant.

Too often, medical staff see their role as tough gatekeepers of the NHS, excluding a public that would demand too much. This demeans the public and those working in the front line of the NHS. If the NHS develops several different front doors doctors may be freed to use their skills without waging a continual battle to persuade members of the public that they do not need further investigation, treatment, or referral.

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1 O'Cathain A, Munro JP, Nicholl JP, Knowles E. How helpful is NHS Direct? Postal survey of callers. *BMJ* 2000; 320:1035. (15 April.)
2 Hayes D. The case against NHS Direct. *Doctor* 2000 Apr 13:36-9.

Clinicians must be able to provide feedback and evaluate advice given

Editor—O'Cathain et al report that most respondents found advice from NHS Direct to be helpful and reassuring.[1] However, mothers of several young children recently admitted to our paediatric department have received advice from NHS Direct that in retrospect was concerning and inadequate. We report one such case here.

The mother of a 6 month old boy telephoned NHS Direct for advice over three consecutive days. He had been unwell with vomiting and increasing lethargy over this period. She was interviewed, and because he was still drinking copious fluids and frequently wetting nappies she was reassured on each occasion. He was subsequently admitted with severe diabetic ketoacidosis.

Although diabetes is rare in infants, lethargy is an important, although non-specific, symptom.[2] Reassuring information, such as the history of adequate fluid intake and urine output, should not be taken in isolation.

Monitoring and audit of NHS Direct are essential, particularly as the evidence for the efficacy of telephone triage in this population is lacking.[3] Some evidence of efficacy has been the absence of major adverse events in recent studies, but are these events being reported?

We attempted to give feedback on this case. The NHS Direct website has no facility for clinicians to give feedback. Use of the NHS Direct telephone line to give feedback led to a succession of telephone calls, culminating in the suggestion that we write to NHS Direct care of the NHS Executive in Leeds.

Users are rightly able to provide feedback via the NHS Direct website and telephone, but attempting to give feedback as clinicians was time consuming, arduous, and unsatisfactory. We strongly recommend that a system for feedback from clinicians be provided and made readily accessible.

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1 O'Cathain A Munro JF, Nicholl JP, Knowles E. How helpful is NHS Direct? Postal survey of callers. *BMJ* 2000; 320:1035. (15 April.)
2 Hewson PH, Humphries SM, Roberton DM, McNamar JM, Robison MJ. Markers of serious illness in infants less than six months old presenting to a children's hospital. *Arch Dis Child* 1990;65:750-6.
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Cost effectiveness and effectiveness in terms of health outcome needs to be determined

Editor—It is not surprising to find that patients like to be able to pick up the telephone and obtain advice.[1] What we need to know is whether the diversion of resources into NHS Direct is cost effective and effective in terms of health outcome.

If the service is used as an additional source of advice by patients who then go along to their general practitioner or an accident and emergency department anyway—or if, even worse, it encourages patients who would have got better anyway to present to their doctor—then all NHS Direct is doing is to give a nice warm feeling to those involved.

No matter how many P values and 95% confidence intervals are calculated, patient satisfaction questionnaires are a soft audit tool and do not constitute scientific inquiry.

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Ramifications of Ledward case

Editor—The case of Rodney Ledward raises two serious concerns.[1]

Firstly, on the presumption that slipshod surgery will result in large numbers of compensation claims, his medical protection society would have early warning of alleged incompetence. Since they have already established the principle of risk categories for subspecialties, did they, do they, or should they have a system of loading or exclusion for high-claim individuals?

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Secondly, it is notable that this and the Bristol cause célèbre have involved very senior staff, who would sail unscathed through any peer led revalidation procedure. For our employer to demand high standards of us is right and proper; but our profession is currently tying itself in knots over this issue when it is the right and duty of our employer—the government—to decide what it wants and to organise it. We must heed the warning of the police complaints authority; police investigating police will never convince the *Guardian* of their objectivity, and neither will doctors revalidating doctors.

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1 O'Neale Roach J. Management blamed over consultant's malpractice. *BMJ* 2000;320:1557. (10 June.)

Doctors' attitudes resemble those of the old aristocracy

Editor—To become a doctor one has to study medicine (for eight to 11 years in France) and pass exams. These exams are necessary to show that the basic medical knowledge has been correctly acquired and that the doctor practises his or her job correctly. It therefore does not seem scandalous that every 10 years or so doctors should have to pass similar exams again.

Morrell wonders whether the medical dinosaurs are heading for extinction.[1] I think that the reluctance of many doctors to have their basic medical knowledge checked at regular intervals resembles the mentality of the old aristocracy. Those people found it natural to have their privileges maintained for their entire lives without feeling any need to justify this.

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1 Morrell P. Doctors and complementary medicine. *BMJ* 2000;320:1145. (22 April.)

Antibiotic prescribing in general practice

Practices should use the technology

Editor—All my prescriptions, except those for controlled drugs, are computer generated. The general practice administration system for Scotland (the commonest practice computer system in Scotland) has a formulary option, which allows me to preset the dose of drug and length of course. I use this option extensively because it saves me time. (It can of course be overridden.) By spending a minute or two converting the formulary entry I have made sure that all my prescriptions for trimethoprim for urinary tract infection are for only 3 days. Presumably other systems have a similar facility. Computers don't get bored or forget that they ought to change behaviour.

This simple and basic procedure might help to remove the need for computerised reminders, loose leaf practice manuals, and educational activities to implement this particular change.[1]

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1 Lipman T, Price D. Decision making, evidence, audit, and education: case study of antibiotic prescribing in general practice. *BMJ* 2000;320:1114-8 [with commentary by T Greenhalgh]. (22 April.)

Authors' solution may not be economically sound

Editor—I enjoyed Lipman and Price's article on antibiotic prescribing in a group general practice and Greenhalgh's dramatic commentary on it.[1] But I come to a different conclusion from the authors. The shorter course of trimethoprim did seem to result in more patients returning, as the nurses remarked, even if the confidence intervals were wide. A quick calculation showed this to add up to 14 consultations over the year. If you cost this out at £20 a visit, the cost of a 3 day course is £280 a year. This is at a time when the administration seems to be making much political capital over appointment times in general practice.

I am going back to 5 day courses of the drug. The evidence from this paper seems stronger than that in the Cochrane Library.

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Study raises several questions

Editor—Often in general practice we take the evidence for the way we practise for granted, not asking how sound this evidence is. It is helpful to read narratives written by general practitioners about their own practices, particularly when these doctors are ready to admit shortcomings or failures. Increasingly we as doctors are asked to justify what we do and don't do.

I wish to raise a few points arising from Lipman and Price's paper.[1] Although the authors conclude that small group educational processes are better for making management decisions, I am not sure it is a safe conclusion that they are better for implementation of these decisions.

I would be concerned if my partners and I had "by consensus" agreed to a protocol (for example, to prescribe trimethoprim for 3 days in uncomplicated urinary tract infection) but a year later "some partners claimed not to have heard the new policy." Lipman and Price do not mention how many general practitioners are in Westerhope Medical Group, but given this breakdown in communication would the use of stronger evidence be better implemented?

I have misgivings that trimethoprim was prescribed for 7 days in 16 cases when no growth was obtained on culture and in 31 cases when no culture was performed at all. The group studied comprised women of childbearing age and older. Trimethoprim is a folate antagonist and contraindicated in pregnancy. There is no mention of whether pregnancy had been excluded; the group may have included women who, in the early stages, were unaware they were pregnant and not taking folate supplementation.

I would question whether too few urine cultures were done before and after treatment. As doctors we strive to optimise our use of antibiotics and often have to treat infections empirically. This, however, should be backed where possible with laboratory evidence. By the authors' protocol a patient could have required a third course of antibiotics before an uncomplicated urinary tract infection was successfully treated. Why was analysis of urine dismissed as not reliable?

Finally, the term "uncomplicated" is not particularly useful and disliked by many bacteriologists; all infections have the potential for complication, especially if they are being treated blind and no cultures are awaited.

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Author's reply

Editor—Syme's point is well made, and the practice computer system has now been changed with regard to trimethoprim for urinary tract infection. As Taylor points out, the shorter course seemed to lead to more patients returning, but the 95% confidence intervals included no difference between proportions (although it could be argued that, had this been a clinical trial, it was underpowered to find a true difference).

Taylor's assertion that "the evidence from this paper seems stronger than that in the Cochrane Library" is flattering but untrue, in that evidence of clinical effectiveness from randomised controlled trials must always be stronger than that from retrospective audits. Taylor argues that the extra consultations resulting from the short courses increase costs and therefore 5 day courses would be preferable. I don't think the figures support that conclusion. But this was a narrative case study, and team members' opinions and actions were also of interest. Some second consultations came about because of clinicians' lack of confidence in the 3 day regimen rather than its failure.

Carvel would be concerned if he and his partners had agreed to a protocol and a year later some partners denied knowledge of it. So would we. The lesson we drew was that we became aware of this only because we started to have regular education sessions in protected time and were therefore able to address the problem. Good communication cannot be taken for granted; it must be worked at, and an educational process proved more effective than an administrative one.

The *British National Formulary* states that trimethoprim is potentially teratogenic in the first trimester. We would regard urinary tract infection in pregnancy as complicated and thus excluded from the guideline. I have not

found reports of fetal abnormalities caused by trimethoprim and would regard a 3 (or even 7) day course as carrying an acceptably low risk in unsuspected pregnancy.

I disagree that we should have done more urine cultures. Only seven of 176 urine cultures at the first consultations grew organisms insensitive to trimethoprim, and not performing a urine culture was a moderate predictor of no second consultation (negative likelihood ratio 0.34). Treating empirically is thus likely to be successful in most cases and reduce the number of second consultations. We plan to repeat the audit for the period July 1999 to June 2000.

Analysis of urine in practice conditions has low predictive values.[1] We critically appraised the paper by Winkens et al and concluded that the results of analysis of urine would not alter our clinical decisions.

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Family history is important in estimating coronary risk

EDITOR—The new Sheffield table and its alternatives make little use of a cardinal risk factor that is easy to assess.[1] A family history of coronary artery disease, especially when premature, is a powerful and independent indicator of a person's risk. Failure to include this element will cause these tables to underestimate the 10 year risk of cardiovascular disease and cannot be corrected for by simply adding six years to the patient's age, as suggested in the Sheffield table. The increase in risk depends on the exact details of the family history and the patient's age and sex.

The GISSI-EFRIM investigators (Gruppo Italiano per lo Studio della Sopravvivenza nell'Infarto-Epidemiologia dei Fattori di Rischio dell'Infarto Miocardico) showed that a family history of myocardial infarction is an independent risk factor for myocardial infarction, with the number of relatives and the age at which they were affected influencing the strength of the association.[2] Compared with subjects without a family history, those with one or two affected first degree relatives had relative risks of myocardial infarction of 2.0 and 3.0 respectively.

The danger seems to be greater for women than for men and is especially high if a sister is affected. In one study of patients aged under 60 with myocardial infarction the cumulative risk to women of ischaemic heart disease before age 65 is considerably higher if a sister rather than a brother is affected (26% *v* 16%).[3]

Using more precise definitions of a family history allows for a more accurate assessment of coronary risk. An Australian survey found that, compared with an affected parent, an affected sibling carries a relative risk of 2.5 for coronary artery disease, regardless of age.[4] Hence any female patients defined by the Sheffield table as having a 10 year risk of coronary heart disease of 15% but who have an affected sister of similar age may actually have a risk of over 30%. Family history of coronary artery disease should feature prominently in all guidelines for primary prevention of cardiovascular disease.

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Prevalence of obesity in asthmatic adults

EDITOR—Obesity is an increasing health problem, particularly in the affluent countries, and although the reported association (not necessarily causal relationship) with asthma is not new, Stenius-Aarniala et al have appropriately reported the effects of weight reduction in morbidly obese adults (body mass index 30-42) with asthma.[1] They have also suggested that, because of the high prevalence of obesity,[2] a large number of patients with asthma will also be obese.

To highlight the findings of the study, in the context of reporting the prevalence of obesity specifically among people with asthma, cross sectional data collected during a previously reported community study based in some of the socioeconomically deprived districts in Birmingham[3] have been newly analysed.

Of the original 689 study subjects with asthma, 535 (77.6%) were adults (293 white Europeans, 242 South Asian) within the age group 18-59 years. Only 38.5% of these adult subjects had a body mass index (kg/m^2) within the healthy range (18.5-24.9), whereas most were either overweight (36.4%, body mass index 25-29.9) or obese (19.6%, body mass index 30-39.9).

At the extremes, 1.7% were severely obese (body mass index >40) and 3.6% underweight (<18.4). The predicted forced expiratory volume in the first second did not vary significantly (range 76.6-79.3) between the different categories. Regression analysis in these subjects showed that there was also an association between body mass index and both age and sex but not with ethnic group. Data overall suggest that almost 58% of adults with asthma in this community were above their ideal body mass index measurements, but we cannot generalize as to the applicability of the reported study[1] and specifically whether weight reduction would have a similar impact in all overweight as well as obese individuals.

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Competing interests: None declared.

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Mentally ill people in prisons

Prison service policy on seclusion has changed

EDITOR—On 30 March 2000 the prison service issued instruction 27/2000, which announced the immediate elimination of the use of strip cells in the management of prisoners identified as being at risk of suicide or self injury. This long overdue decision on policy may be heavily influenced by the Human Rights Act 1998. Interestingly, the prison service cramps governors' budgets by stating that alterations to create a safer cell have to be met from existing capital resources.

I agree with Reed and Lyne's proposal that the care of mentally ill offenders should be provided within the NHS.[1] We in the prison service can never provide inpatient care to NHS standards. We do not have the funds to do so even though we are measured by those same standards. Furthermore, we do not have 24 hour access to our inpatients, even when it is described as a 24 hour service. Every prison has patrol states—during parts of the day and all night—when every prisoner is locked away. Nurses do not have routine access to their inpatients.

The present system is dishonest and duplicitous. It is dishonest because we provide it in name only, and it is duplicitous to attempt to provide a parallel system to that of the NHS, which is already funded for the individual as part of capitation funding. The Home Office and the Department of Health are tripping over each other in accessing funds from the Treasury to provide a service for the same individual—prisoners are resourceful, but they cannot be both inside and outside at the same time.

Prisons should have several dependency cells on the wings. Those prisoners who require regular visits from community nurses could be located in these cells. Prisons should enter into joint funded initiatives with local primary care groups to secure "visiting rights" from NHS trusts' community based nursing teams. Nurses, acting in these team models, should be employed under local NHS parenthood, not by the prison service. Nurses within the prison service would experience little

change to their environmental conditions. They would benefit by rejoining a more mature professional structure. Clinical supervision and clinical governance are already integral components of that structure. The same benefits could be said to apply to our medical colleagues.

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1 Reed JL, Lyne M, Inpatient care of mentally ill people in prison. *BMJ* 2000;320:1031-4. (15 April.)

Little has changed

EDITOR—I welcome Reed and Lyne's honest and comprehensive assessment of mentally ill people in prisons.[1]

I think, however, that, save a few inexpensive tamperings, nothing will be noticeably altered as a consequence of his findings. Reed has updated similar findings made by John Howard in 1780,[2] but little has changed since then either, from a custodial point of view.

Howard wrote: "In some few jails are confined idiots and lunatics … many of the bridewells are crowded and offensive, because the rooms which were designed for prisoners are occupied by lunatics.… The insane, when they are not kept separate, disturb and terrify other prisoners. No care is taken of them, although it is probable that by medicines, and proper regiment, some of them might be restored to their senses, and usefulness in life."

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2 Howard J. *The state of prisons in England and Wales*, 2nd edn. Warrington, 1780:10.

Care is required with cost effectiveness approach

EDITOR—The argument in the letter from Taylor and Ebrahim starts from the premise that the cost of providing an anticoagulation service for patients with atrial fibrillation is 15 times higher than that of treating with aspirin.[1] The inference that anticoagulation must be shown to be 15 times as effective as aspirin in the prevention of stroke is not correct because it ignores the costs of treating patients who develop strokes.

The point estimate and confidence intervals of the treatment effect shown by Hellemons et al[2] could be combined with the estimated costs of both preventing and treating strokes. In this way a model of cost effectiveness related to different baseline risks could be constructed. This, however, is rather different from the way that Taylor and Ebrahim suggest using the cost ratio. It is indeed unlikely from the trial data that anticoagulation is 15 times as effective as aspirin, but this does not mean that anticoagulation must prevent 15 times as many strokes to be cost effective.

Since the overall cost of treating patients with stroke is likely to be higher than the cost of drugs for preventing stroke, a relatively small benefit from anticoagulation might lead to an overall cost benefit in comparison with aspirin. This will be increasingly likely as the baseline risk of stroke increases.

As authors of other letters in the cluster have noted, the confidence intervals of the relative risk found by Hellemons et al are not tight enough to rule out a moderate beneficial effect of anticoagulation in comparison with aspirin.[3] Although cost should be considered in choosing between aspirin and anticoagulation for patients with atrial fibrillation (alongside individual patients' risks and preferences for treatment), it should not be used to demand that the statistical difference between treatments matches the differential costs of one part of the service provision.

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2 Hellemons BSP, Langenberg M, Lodder J, Vermeer F, Schouten HJA, Lemmens T, et al. Primary prevention of arterial thromboembolism in non-rheumatic atrial fibrillation in primary care: randomised controlled trial comparing two intensities of coumarin with aspirin. *BMJ* 1999; 319:958-64.
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Assessment of competence and performance at interview

EDITOR—We read the paper by Wood and O'Donnell on an overhaul of the traditional interviewing system with interest.[1] They have identified an important area in medical education and assessment that needs to be addressed. Our current processes of selection pale into insignificance compared with those for industry, but two issues need to be considered.

Firstly, as a profession we seem to have difficulty in giving constructive and honest feedback to doctors working with us and in references. If we were able to give constructive criticism more effectively, there would subsequently be less need to measure competence through objective structured clinical exams or other means at an appointment process.

Secondly, at interview we often lack skills in assessing performance. It is possible through structured questions and experiential interviewing to assess how a candidate performed in a series of situations, rather than evaluate how they might perform in a fictitious situation. In the North Western Deanery we have been working with a group of consultants to identify a range of questions that ask candidates—"Tell us about a time when …," rather than, "What would you do if …". This change in emphasis gives a much greater insight into previous performance, which is usually the best indicator of future performance. It has also encouraged us to think about the professional values we seek in doctors who apply to join our training schemes, rather than experience that they have to date.

We do need to develop better evaluation of performance and competence in the workplace, and we need to become more skilled at interviewing, particularly in identifying professional values. However, objective structured clinical exams are expensive in time and resources and may not be appropriate for selection processes. More effective and honest references and experiential interviewing might help us to select at interview more effectively.

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1 Wood L, O'Donnell E. Assessment of competence and performance at interview (Career focus). *BMJ* 2000;320: S2-7321. (5 February.)

Drug use and weapon carrying by young people

Study did not go far enough

EDITOR—Use of illegal drugs by young people seems to be increasing, and a rational and effective response must be guided by sound science. McKeganey and Norrie's paper on the association between use of illegal drugs and weapon carrying by young people in Scotland is based on three surveys in 20 Scottish schools.[1] How these schools were selected and how representative they and the students surveyed are of schools and students in Scotland generally are not reported.

The paper describes an association between use of illegal drugs and weapon carrying, both measured by self report with an instrument developed by the study team. No details are given to allow assessment of the validity or reliability of this instrument. Use of illegal drugs is undefined but seems to relate to the number of different illegal substances ever used. Weapon carrying was defined in terms of lifetime, rather than recent, carriage. Thus these data could suggest that weapon carrying is high among students now, or that many students have carried a weapon at least once in their life, or that neither is the case.

The data suggest that students reporting lifetime weapon carriage are more likely also to report using more kinds of illegal drugs. This association could be an artefact generated through a common reporting tendency, it could be an example of confounding (drug use and weapon carrying sharing the same antecedents), or it could be causal (drug use leading to higher probability of carrying a weapon).

As corroboration of self report was not sought, reporting bias cannot be discounted. Both drug use and weapon carrying are likely to be associated with social disadvantage: in table 3 twice as many students from Lanarkshire schools reported having carried a weapon as did those from independent schools. Despite this the proportions presented in table 2 are not standardised for social position. Whether drug use preceded weapon carrying or vice versa and the

temporal relation of both to numerous other potential confounders cannot be assessed since the study was cross sectional.

The authors acknowledge that their study does not clarify the causes of weapon carrying. We suggest that it provides little clarification of anything. Such a report, appearing in the General practice section of the *BMJ* and widely publicised in the popular media,[2] may subliminally reinforce the image of young drug users as violent criminals. This is unlikely to encourage general practitioners to engage with drug users and is counterproductive in the context of recent advice both from the Department of Health and in the *BMJ*.[3 4]

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Authors should have phrased questions differently

Editor—The research by McKeganey and Norrie is plagued by conceptual problems, which compromise its value.[1] The authors asked participants "Have you ever carried a weapon in case you got into a fight?" and "If yes, what kind of weapon(s)?" Reporting on the data generated by their inquiry, McKeganey and Norrie remark that "It is far from clear why a substantial number of young people in Scotland feel the need to carry a weapon, and this needs further investigation."

The reason why a substantial number of young people in Scotland feel the need to carry a weapon was proposed by McKeganey and Norrie themselves, in the question that they asked in their survey. Many young people in Scotland carry a weapon in case they get into a fight. Surely the survey would have yielded more interesting data about weapon carrying among young people if McKeganey and Norrie had asked respondents to offer up some reasons for their carrying weapons. The offending question, however, obviated this possibility and perhaps shows a bias on the part of the researchers concerning their beliefs about the cause(s) of weapon carrying by young people.

The second problem concerns the ambiguity of the word "fight," which can refer to verbal confrontations, planned physical confrontations, anticipated physical confrontations, and fear of unprovoked physical assault. Indeed, even the phrase "fear of unprovoked physical assault" is rather broad since one may fear a foreseeable physical assault or have a general fear of victimisation.

The study prompts three thoughts. Firstly, the questions asked suggest that the only interesting kind of weapon carrying behaviour is the one associated with the young person's appreciation or perception of the possibility of getting into a fight. Secondly, it would have made more sense to provide respondents with the opportunity to explain why they carried weapons. Thirdly, the limitations intrinsic to the phrase "in case" precluded any opportunity to learn more from the respondents about the types of feelings and beliefs that may motivate a young person to carry weapons.

I offer one final observation. If I was a lad seeking to hinder a research project I would report that not only did I routinely take many different kinds of drugs but I regularly went about the town armed to the teeth.

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Ectopic pregnancy with oral contraceptive use has been overlooked

Editor—In their review of ectopic pregnancy, Tay et al report that previous female sterilisation and current use of an intrauterine contraceptive device are risk factors only when patients with ectopic pregnancy are compared with pregnant controls and not with non-pregnant women.[1] However, we published a review on the effects of oral contraceptives after fertilisation, in which we reviewed data indicating that the ratio of extrauterine to intrauterine pregnancies is increased for women taking combined oral contraceptives and progestogen only pills, compared with control groups of pregnant women not using oral contraceptives.[2]

The increased odds ratio of ectopic pregnancy in women taking the combined pill (compared with pregnant controls) was found to be 4.5 (95% confidence interval 2.1 to 9.6)[3] and 13.9 (1.8 to 108.3)[4] in studies including a total of 484 women with ectopic pregnancies and 289 pregnant controls. We used these odds ratios to estimate that in the studied populations the absolute rate of ectopic pregnancy in women using combined pills would range from 0.7 to 19.9 ectopic pregnancies per 1000 woman years. We could, however, find only one study, from Zimbabwe, that reported an absolute risk of ectopic pregnancy in women taking the combined pill—an ectopic rate of 0.5 per 1000 women years.

The increased odds ratio of ectopic pregnancy for a woman taking progestogen only pills (compared with pregnant controls) was reported in one study to be 79.1 (8.5 to 735.1),[5] which we used to estimate an absolute risk of 4-79 ectopic pregnancies per 1000 woman years. This prediction is reasonably concordant with the reported absolute rates of ectopic pregnancy in women taking progestogen-only pills of 3-20 per 1000 woman years.

Like Tay et al, and most researchers in this field, we restricted our review to studies using pregnant controls because when considering the situation where a woman became pregnant during the use of a birth control agent one should focus on pregnant controls.

We believe that the association of ectopic pregnancies with oral contraceptives has been overlooked in the medical literature on ectopic pregnancy and that most who prescribe or dispense oral contraceptives are not aware of this association. If a woman who is taking an oral contraceptive presents with pelvic pain and unusual vaginal bleeding, we would recommend that the possibility of ectopic pregnancy be ruled out by using the wise and practical clinical approach suggested by Tay et al.

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Implementing honesty about screening using community informed consent

Editor—We support Raffle's suggestion that honesty about screening is the best policy.[1] But how can that be achieved? Practitioners and planners complain that individual informed consent to screening is too time consuming: the provision of information and the necessary discussion and reflection on it require considerable effort, time, and skill.

We have recently suggested a community informed consent process: a survey to establish the distribution of preferences among fully informed people potentially to be screened—for example, from a random sample of the target population to whom screening will be offered.[2]

Firstly, if most of the target population think that the harms of screening outweigh the benefits, there is no need to consider further whether screening should be provided.

Secondly, if most of the target population think that the benefits of screening outweigh the harms, screening can be offered, subject to an acceptable cost effectiveness ratio. People should be informed that a representative sample of people like them who have been given detailed information about the screening process thought that the benefits outweighed the disadvantages. For many, that may be sufficient for them to decide about screening. Some may still want more information, which should then be provided.

Finally, if the target population is divided about benefits versus harms, then there is a need for individualised decisions.

The first step is providing good evidence about all the effects of screening on the basis of randomised trials. We do not see it as a dilemma if people are deterred from effective screening when they know its consequences. If they are truly well informed, that represents their preferences and reflects how they trade the benefits against the harms. Rather, the dilemma is how to ensure that people indeed have sufficient information to make the choice. The community informed consent process represents a practical solution. Only when adequate community surveys of preferences show that most of those who might be screened would choose to be screened does it seem ethical to actively promote screening without detailed individual consent.

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Drugs do not only relieve male menopause

Editor—Gould, Petty, and Jacobs debated about facts for and against the existence of a male menopause.[1] Both positions focused on sexual dysfunction. Jacobs referred to a new class of drugs that offer significant therapeutic potential for male erectile disorder. But no one mentioned the impact of drug abuse or drug treatment on the decline in sexual interest and potency.

For example, it has been described that more than 41% of hospital inpatients aged 65 years and over were found to use benzodiazepines and alcohol in excess[2] and that drug treatment account for erectile dysfunction in approximately 25% of cases.[3] In developed countries, ageing (in men and women) is associated with an increase in the consumption of medical drugs. This contributes to improve the health of ageing people, although it also increases the risk of adverse events related to drug treatment. Drug related sexual dysfunction is distributed dependent on age and sex (unpublished data). Sexual dysfunction should therefore be more prevalent in young women (because they may be taking psychotherapeutic drugs), whereas in the male population, old men should be more affected (principally because they may be taking antihypertensive drugs and psychotherapeutic drugs).

The lifestyle in developed countries could play a more important part in sexual dysfunction than physiological changes related to ageing. Drug treatment is an important matter in this lifestyle and could explain more cases of sexual dysfunction initially attributed to the supposed male "climacteric." Nowadays, the media are focused on new treatments for sexual dysfunction, and they forget that drugs also produce it.

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Tinea capitis should be on the public health agenda

Editor—We welcome the article by Gibbon et al drawing attention to an increasing problem of tinea capitis caused by *Trichopyton tonsurans*.[1] In seeking to document the increase the authors cite that the Communicable Disease Surveillance Centre has recorded a 25-fold rise in cases of infection with *T tonsurans* infection since 1995, and a further doubling of incidence was seen within the first half of 1999. We believe that the magnitude of the rise given by these figures is misleading.

The current laboratory reporting regulations request that, of fungal laboratory isolates, only deepseated fungal infections are reported to Communicable Disease Surveillance Centre.[2] Although substantial numbers of superficial mycoses are reported to the centre each year, the fact that reports are not requested, and therefore not received from most laboratories, hinders any meaningful interpretation of changes in numbers of these reports. Any apparent trends in reports of superficial mycoses are as likely to reflect changes in local laboratory staff, and their understanding of reporting requirements, as they are to reflect changes in incidence.

The rise in *T tonsurans* cases cited by the authors represents three cases reported in 1996, 1 in 1997, and 26 in 1998 (a total of 79 were received in 1999) from all NHS and Public Health Laboratory Service laboratories in England and Wales. Of the 105 reports received in 1998-9, most were from a single laboratory.

At present there is no national surveillance of infection with *T tonsurans*. Laboratory reporting guidelines for mycoses are currently under review. Making *T tonsurans* a reportable fungal infection may provide a means of monitoring trends in tinea capitis, although a substantial proportion of diagnoses will be made on clinical presentation only and therefore will not be included in laboratory reports.

The Public Health Laboratory Service Mycology Reference Laboratory has since 1980 undertaken a five yearly survey to monitor changes in incidence of different dermatophyte species. The number of isolates of *T tonsurans* and the proportion of all dermatophytes reported to the Mycology Reference Laboratory increased from 0.3% (17/5101) in 1980 to 2.5% (363/14811) in 1995.

Clearly there are concerns that the incidence of tinea capitis is increasing in England and Wales. Tinea capitis should be on the public health agenda, given its ubiquity and potential for permanent hair loss and scarring. Further epidemiological research is needed to establish risk factors for development of tinea capitis and to inform local interventions.

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Perhaps it is not time to switch from whole cell to acellular pertussis vaccine

Editor—Although we agree with Finn and Bell that it is an opportune moment to review the British policy on the use of pertussis vaccines, we cannot agree with their conclusion.[1] There is ample evidence that in older children adverse events are less common after the acellular than after the whole cell vaccine, but this difference becomes less significant when the vaccine is given at two, three, and four months as in the United Kingdom.

Miller et al showed that using the current British schedule, of the relatively minor reactions only fever was significantly commoner in those receiving the whole cell vaccine, whereas in older children other mild or moderate reactions were also significantly more common.[2] The study performed by Bell et al looked only at relatively minor adverse events such as local reactions and fever. The study cited by Finn and Bell as showing a difference in incidence of febrile seizures and hypotonic-hyporesponsive episodes was, we assume, conducted at two, four, and six months, as is the norm for Canada. These results cannot therefore be extrapolated to the United Kingdom schedule where one

would expect a lesser difference, if any, between the two sorts of pertussis vaccines.

In considering the use of any vaccine, it goes without saying that the efficacy of the vaccine should also be taken into account, but this seems to have been overlooked in the present discussion. The whole cell vaccines used in the United Kingdom have been shown to be more efficacious than all but the acellular vaccines with five components, which is not available in the United Kingdom.[3] While pertussis still kills children in the United Kingdom, this is an important consideration.[4 5] Uptake of whole cell vaccine is currently 94% overall, and there is no evidence to suggest that by adopting an acellular vaccine, the number of children being immunised would increase. If this turns out to be true in practice the protection afforded to the community would in effect be reduced. Before this can be accepted it would have to be shown that there was a substantial gain in terms of fewer side effects. We are not convinced that this has been done.

The voice in the wilderness is not always wrong, and we should resist the temptation to change our policy just to conform.

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Combination treatment seems rarely to be used in psoriasis

Editor—Ashcroft et al report a systematic review of the comparative efficacy and tolerability of calcipotriol, a synthetic vitamin D_3 analogue, in chronic plaque psoriasis.[1] We have recently completed a general practice based audit of the treatments offered to patients with mild to moderate chronic plaque psoriasis.

We found that only three of 14 patients who had been prescribed a corticosteroid were using a vitamin D_3 analogue as part of combination treatment. The remainder had not received a vitamin D_3 analogue at any time. Despite the risks of using topical steroids, corticosteroids still remain the preferred treatment for psoriasis, and on average 55% of patients receive potent topical steroids.[2] Combination treatment with vitamin D_3 analogues and corticosteroids has been recommended for mild to moderate plaque psoriasis in numerous trials.[3–5]

Although our study is limited by its small sample size, and we cannot conclude that these results reflect general trends, we suggest that the reasons why this combination treatment has not been implemented should be investigated: is it a cost issue? Patients should be reviewed so that a decision can be made on which ones should be offered combination treatment. Perhaps topical corticosteroids should be considered only in those with a poor therapeutic response to calcipotriol.[4]

If a corticosteroid is used for chronic plaque psoriasis, consideration should be given to prescribing it together with a vitamin D_3 analogue, since combination treatment is more efficacious than corticosteroids alone.[3] We postulate from our small audit that although this treatment protocol is recommended, doctors are unaware of it; this needs to be addressed to provide optimal care.

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Psychoactive drugs may have role in pressure sore origin

Editor—Several letters in the *BMJ* address the need for more research into the origins of pressure sores.[1] One aspect that merits consideration is the use of psychotropic drugs in frail elderly people in long term care who have moderate to advanced degrees of dementia.

In a one year study in long term care falls related to psychotropic treatment were associated with the development of pressure ulcers. Eighty five per cent of falls were associated with a psychotropic or psychoactive drug. Some 13 (65%) of the 20 pressure ulcers that occurred during the study developed within two weeks of a fall and immobility related to a fall. Psychoactive and psychotropic polypharmacy, antipsychotic drugs, benzodiazepines, metoclopramide propoxyphene, antihistamines, and antihypertensive drugs were most commonly implicated. The average cost per fall was $754, which included the costs of all documentation, treatment of injuries in the 48% of those who fell (haematomas, lacerations, fractures, pressure ulcers), and related visits to emergency departments and admissions to hospital.[2 3] Interventions by consultant pharmacists to reduce falls and associated injuries by reducing the psychotropic and psychoactive "load" resulted in a decrease in falls from 0.40 to 0.06 per patient per month when accepted and sustained a rate of 0.28 falls per patient per month when rejected.[4]

The current mandate in the United States under the Omnibus Budget Reconciliation Act to taper psychotropic drugs in all nursing facility residents at least two to three times during the first year of residence is based on the apparent harm when these drugs are simply used as chemical "restraints" that produce unacceptable morbidity. Further studies are needed to determine the role of drugs in the development of pressure sores.

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Underlying psychological distress must be addressed in chest pain

Editor—The editorial by Capewell and McMurray states that a rapid cardiological assessment service may reduce admissions of patients with chest pain.[1] Such clinics apparently offer risk stratification, an exercise electrocardiogram, and review by a skilled hospital cardiologist. This approach also reduces worry about missed cases of coronary heart disease.

Capewell and Murray quote Davie et al who described the 49% of their series of 317 patients with non-cardiac chest pain as being immediately reassured by a rapid assessment chest pain clinic and to have a high degree of satisfaction at six month follow up. These results, described as crucial by the authors, surprise me. With a consultant cardiologist and psychiatrist, I reviewed a series of 195 first time attenders at a secondary referral centre in a hospital in inner London.[2] Psychological questionnaires were returned by 113 (58%) patients. Measures used included the hospital anxiety and depression questionnaire, the symptom checklist 90 revised (SCL-90), and the illness behaviour questionnaire. Fifty-two (46%) of the responders presented with chest pain, and of these 23 (20%) had typical anginal pain whereas 29 (26%) had atypical chest pain. After review by the consultant cardiologist and investigation as clinically indicated, 56 (50%) of the patients had a cardiac diagnosis and 57 (50%) had non-cardiac symptoms. Forty (35.4%) of the population had serious psychological distress. Logistic regression exploring the absence of a cardiac diagnosis yielded only two weak predictors, young age and a clinically significant score on the somatisation subscale of the SCL-90.

The degree of psychological distress among those presenting with cardiac symptoms is high, and I am surprised that users of chest pain assessment services are reassured and hold on to such reassurance over time without the underlying psychological distress being addressed. Somatisers attending cardiology centres may continue to present at some level of care provision, particularly primary care. An outcome measure that included repeat presentations with non-coronary chest pain would answer this important resource question. Somatisation can be explained as a response to transient stress, but it can also herald persistent distress, care seeking, and disability. When unnecessary admissions are avoided illness behaviour may well be reduced, as there is no reinforcement of hypochondriasis through hospital admission. Non-coronary chest pain is a challenge as there is so much potential to reduce costs, minimise distress, and identify somatisation.

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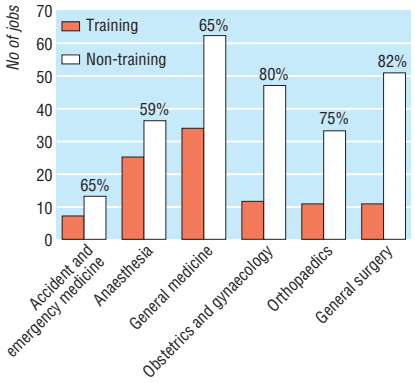
Is distribution of vacancies for hospital jobs a reflection of new NHS?

Editor—The NHS is undergoing unprecedented changes. Hospital trusts are being asked to supply continued quality care while restructuring and modernisation continue apace. In addition, doctors' hours have been cut and the number of specialist registrar training posts recommended by the Surgical Workforce Advisory Group is falling in several acute specialties. To maintain service commitments to the community how are trusts coping?

We audited the employment practice of NHS trusts by counting the number and type of jobs available in six front line specialties. We recorded all job vacancies, from consultant to any level above senior house officer, advertised in the eight *BMJ* Classified sections of August and September 1999. Many middle grade posts were advertised under various titles not in common use, such as medical officer, trust specialist, clinical specialist, and trust doctor. We classified these posts, which did not include a training component, as a miscellaneous group. To exclude locum posts covering short term leave we did not count posts of less than one month's duration.



Number of jobs with training components (specialist registrar and locum appointments for training) or non-training components (locum appointments for service and miscellaneous) by specialty. Proportion of non-training jobs for each specialty is indicated

The table summarises the number of posts advertised in this two month period. In obstetrics and gynaecology, orthopaedics, and general surgery over three quarters of advertised middle grade posts had no provision for training. There was a paucity of advertised consultant posts in both accident and emergency and obstetrics and gynaecology, the former having a high proportion of staff grade posts and the latter a high proportion of locum appointment for service posts. The figure shows the numbers of training posts and non-training posts by specialty.

Many of the advertisements did not specify the number of posts available, and this could influence the study's accuracy. Short of contacting every hospital in the country, however, this is the simplest method of ascertaining the pattern of employment practice currently being pursued by trusts. The results highlight the large number of non-training posts being advertised in comparison with those that include a training component.

Specialist registrars and locum appointments for training have recognised supervised education as part of their job. Consultants and staff grade doctors are obligated to continued postgraduate development. In contrast, non-training grade juniors receive no structured training, and no educational support exists for them. This raises concerns that employing trusts may not always realise the importance of ensuring appropriate access to education and training for this group of doctors. Many of these doctors perform considerable amounts of out of hours service; the developing situation raises questions about risk management when a sizeable proportion of the service is being delivered by doctors who have no contractual expectation of education and yet are not fully trained.

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Summary of number and type of posts advertised in August and September issues of *BMJ* Classified

	Consultant	Staff grade	Specialist registrar	Locum appointment		Miscellaneous	Total
				For training	For service		
A&E	13	20	4	3	4	9	53
Anaesthesia	42	30	11	14	18	18	133
General medicine	41	13	18	16	32	30	150
Obstetrics and gynaecology	17	5	4	8	33	14	81
Orthopaedics	18	4	6	5	5	28	66
Surgery	39	8	7	4	15	36	109

A&E=Accident and emergency medicine.

Use of polymorphism analysis requires ethical guidelines

Editor—In their review on pharmacogenetics Wolf et al state that one day it may be considered unethical not to carry out pharmacogenetic testing routinely.[1] I agree, but the ethical use of such testing must be clearly defined.

Because of advances in microarray technology (DNA chips) a DNA profile could soon be obtained either in the local pathology laboratory or with a point of care device. The DNA chips can perform thousands of polymorphisms at a time. Should the doctor treat requests for pharmacogenetic testing in a similar way to requests for measurement of urea and electrolyte concentrations and request them without specific consent? Or does genetic testing have such implications that requests for it should always require specific consent?

The relation between genotype and phenotype is not always clear, and unexpected findings can occur. The association of the ApoE E4 genotype with Alzheimer's disease should serve as a cautionary tale.[2] Investigations into the apolipoprotein E polymorphisms in familial hyperlipoproteinaemia later showed an association of one of these polymorphisms with Alzheimer's disease. This resulted in a considerable ethical dilemma for doctors and potentially their patients.

I share the belief that polymorphism analysis will have a major impact on health care, but ethical guidelines must be determined before its widespread use.

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